IDPH FLEX CAH QI Regional Meeting Notes

07/15/14 - Atlantic Group – Current CAH Landscape Discussion

- Reimbursed yet CMS wants to change how they perform quality /ACO-wise [volume vs. performance]
- Practice setting changing from inpatient to outpatient – won't be paid for the acute care inpatient (won't have as many and won't be paid as much for the ones you do have)
- No 'playbook' or rule book for CAHs – we are still guessing totally.
- We try to do everything that the PPS hospitals are required to do, but we still don't know and are trying to guess – with less staff and resources than PPS hospitals
- I still have 9 years before I can retire
- Accountable Care Organizations??? How that will impact commercial insurance or industries in your local community??? (Wal-Mart contracted with Virginia Mason)
- This all speaks to how 'outside the box' we all have to think

Notes from Quality Data Reporting Discussion

- Orange City – Val Droog –
    - The surgical pt was given Vancomycin as a prophylactic w/i 60 minutes – but the protocol is supposed to be 60 to 120 minutes because it is a longer half life.
    - In CART when Val enters vanco – it does not change the timeframe. It fails the measure – she goes by the CART reports (measure fails – looks at aggregate first and percentage and then dives in to each measure specifically.) Appropriate care for the patient but doesn't meet the measure.
- Montgomery County – Holly
    - CHF pt was 94 years old and the physician was not going to perform an echocardiogram. However, the physician did not document the reason for not doing the echo. This pt failed the measure.
    - Montgomery County Hospital has considered looking at measures involving 'scope' procedures. SCIP Measures involving 'scopes'.
    - Care Coordination – timeframe within scope procedures.
- Alegent – Anne
    - All of their heart failure fallouts go to the peer review med staff committee.
- Cass County – Jennifer
    - Each measure fall out is documented as an incident report which goes back to the provider and to the department.
- **No one considering not reporting.**

07/16/14 – Storm Lake Group - Current CAH Landscape Discussion

- Burden of data collection – different people wanting, needing data…with limited resources for everyone, we want to collect data that is meaningful to us and valuable to us not just because someone wants it.
- No time to raise up from just collecting the data to doing quality improvement projects
- Loss of IHA Quality Databank (never received survey results)
- Moving forward with the HEN with the loss of the IHA Quality Databank, they have lost the comparative data with peer group/network group
- Try to look at the value add for the hospital prior to just starting to reporting more data – what are you doing with the data? (the first hurdle is just getting the data?) – get frustrated with just reporting the data to someone else just to collect data
- Discrepancies between the IPPS and CAH systems. Because we at the CAHs don't have time to worry about measures that aren't meaningful to us (small n's and rates that aren't representative of the care that we give.)
- Is CMS looking at readmission rates between level of care changes? One provider that is giving quality care but has an astronomical readmission rate.
- What is happening at the hospital payment level and the provider payment level is different and you will never change the hospital readmission rate until you restructure the provider payment rate – there is a disconnect.

07/22/14 - Ottumwa Group - Current CAH Landscape Discussion

- Board members hear items pertinent to PPS hospitals, and not understand that it doesn't apply to CAHs.
- Unknown is worse than actually knowing. The wait for the CAH final rules. Already under the sequestration loss and the operating margins are less and you just hope your hospital will survive it all.
- Feels like purgatory and not knowing how things will develop with so many things going on – ICD10, EHRs, measures.
- Webster City – Van Diest Medical Center – Just started meeting in January with community stakeholders. Have created an universal transfer form which the hospital and each of the nursing homes will use. Next step will be diving into each individual patient.
- Albia – Monroe County – have also just started meeting. Have invited every stakeholder that touches the patient including law enforcement and magistrate. In process of establishing goals. Planning on having a couple of patients attend the meetings and have had other people ask to attend the meeting. Trying to look outside of the box and trying to provide resources as part of the goal to keep the patient from having a readmission. Looking at the Ft. Dodge model in providing a home visit (free). There were about 18 people at the first meeting. Good to hear from

the stakeholders and their perspective of what happens when patients are transferred from the hospital to their facility. (Invited the Lab & Radiology Manager due to issues identified – she will be attending an upcoming meeting to present corrections which have been made.) Looking at an universal transfer form. Goal to get information required in both places (hospital and nursing home) even though the patient is followed by the physician from hospital to nursing home.

07/23/14 – Waterloo Group - Current CAH Landscape Discussion

- Community members hearing things – "hospital won't be paid for readmissions anymore," "physician reimbursement changing" – want to educate their public
- Education for the hospitals on what KePRO is/new process for their Medicare Beneficiaries and changes within the QIO's and QIN's mean for them and their patients
- Community group meets regularly but bringing the 'assisted living' staff along seems to be the greatest challenge. The nursing homes seem to get it. It's hard to get the clinics there. Had to back off from initial goals and just focus on the advance directives
- The community group is valuable but it is hard to keep the excitement and it's hard to keep the resources available to keep the momentum forward – it has fallen to the hospital and is hard to keep everyone interested and engaged. Has been good with good outcomes but it has been challenging.
- Just keeping up with everything is a challenge.
- Quality data reporting requirements
- Wear multiple hats and it's hard to know where to concentrate your efforts and prioritize. Hospital has gone through a tremendous amount of change with health system changes and affiliations.
- Hard to keep up with the regulations and what is required by government in a short amount of time and coordinate with community stakeholders such as nursing homes who have fewer resources (EHR)
- Higher acute - intensity patients go to larger hospitals and the your CAH has fewer patients and then the patients you do have look worse on quality indicators.